STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from August 29, 2013 through September 4, 2013. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 survey sample was 17.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	1. The MDS for R23 dated 5/21/13 & 8/12/13 have been corrected and submitted. 2. All Residents have the potential to have oral/dental status accidently coded incorrectly. 3.Oral assessments and the MDS's will be reviewed weekly by the MDS Coordinator and the ADON for accuracy. See attachment A 4. Findings of the Oral Assessment review will be reported to the DON weekly until the MDS accurately reflects oral status for 4 weeks. Findings will then be reported monthly until the MDS reflects accurate oral status for 4 months. Oral Assessment reviews and findings will be reported quarterly to the CQI committee by the MDS Coordinator.	9-10-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

A Cecile Jeringue | adon | 9/23/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status of loose upper dentures for one (R23) out of 17 Stage 2 sampled residents. Findings include: R23's nursing oral assessment, dated 5/20/13, revealed that R23 was assessed under "Teeth/Dentures" as having "poor fitting dentures". Review of R23's annual MDS assessment, dated 5/21/13, revealed that R23's "Oral/Dental Status" was only coded for "No natural teeth or tooth fragment(s)", but not coded for any denture problems. R23's nursing oral assessment, dated 8/12/13, revealed that R23 was assessed under "Teeth/Dentures" as having "poor fitting dentures". Review of R23's quarterly MDS assessment, dated 8/13/13, revealed that R23's "Oral/Dental Status" failed to be coded to indicate the resident had denture problems. During an interview with R23 on 8/29/13 at approximately 10:01 AM, it was observed that the resident's upper dentures moved as she spoke. During an interview on 9/3/13 at 1:44 PM, E4	F 278		

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F 278	Continued From page 2 (Registered Nurse Assessment Coordinator/RNAC) confirmed that the above MDS should had been coded for loose dentures after reviewing all of the oral nursing assessments. E4 stated that the nurses filled out the MDS assessments and completed the oral assessments, and she entered the information from the MDS forms as it was submitted to her. E4 stated she would check the oral assessments in the future. The facility failed to ensure that the annual MDS assessment, dated 5/21/13, and the quarterly MDS assessment, dated 8/12/13, accurately reflected R23's status for her upper dentures being loose.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible with regards to exposed wires on the bed controllers in three residents rooms (103, 204, and 221) out of 17 rooms inspected. Findings include:	F 323	1. Bed controllers in Resident rooms 103, 204 and 221 were immediately replaced. 2. All Residents have the potential to be affected by bed controllers. 3. Bed controllers for all Residents have been replaced as it was already planned to replace them. Beds and Bed controllers will be checked monthly by the maintenance department and findings will be reported to the Maintenance Director. See attachment B 4. The Maintenance Director will report findings to Safety Committee quarterly.	9-11-13

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F 323	Continued From page 3 An observation of resident room 221, on 8/29/13 at 10:04 AM, revealed there were exposed wires on the bed hi/low controller located on the floor on the right side of the bed. Observations made during the environmental tour with E5 (Maintenance Director) on 9/4/13 at approximately 9:15 AM revealed there were exposed wires on the bed controllers in resident rooms 103, 204 and 221. In an interview with E5 (Maintenance Director) on 9/4/13 at approximately 9:15 AM, he confirmed these findings and stated that the insulation was missing from the wires, but that it was low voltage (24volts). In an interview with E1 (Mother Superior), E2 (Administrator) and E5 on 9/4/13 at approximately 2:15 PM, E5 stated that their system for checking the bed controllers consisted of the nurses inspecting the bed controllers and letting maintenance know by writing a ticket if there was an issue. E1 stated that the certified nurse's aides also report issues. E5 stated that maintenance staff did not have a system in place to check the bed controllers on a regular basis. The facility failed to ensure that the resident environment remained as free of accident hazards as was possible with regards to exposed wires on bed controllers in three (3) rooms. The facility failed to have a system in place to check the bed controllers regularly.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 4 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility had three (3) out of three (3) medication storage rooms which contained expired medications.	F 431	1. All expired medications were immediately destroyed. E3 did report the four bottles of Maalox were not for Residents as there were no longer any Residents for whom it is prescribed. 2. All Resident have the potential to be affected by expired medications. 3. All medications have been checked by administrative nurses for expiration dates. Medications that expire this year have a orange sticker placed on them and the month of expiration is written on the sticker. Medication carts and medication storage areas will be checked each month by the 11-7 nurse and expired medications will be destroyed. Findings will be reported to the DON. See attachment C 4. The Consultant Pharmacist will conduct random spot checks for expired medications monthly and ensure monthly checks are done by 11-7 staff until no expired medications are found during 4 random spot checks. Findings will be communicated to the DON. Thereafter findings will be reported to the CQI committee quarterly.	10-4-13

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F 431	Continued From page 5 Additionally, one (1) out of two (2) medication carts contained expired house stock (drugs not labeled for a specific resident) medications. Findings include: The facility's policy entitled, "Medication Disposal," dated 7/2005, stated "When medications are discontinued they shall be removed from the Unit either by destruction or by returning them to the Pharmacy. Purpose: To ensure that discontinued medications, regardless of their route, do not remain either in the medication cart or the medication room..." 1. An observation on 8/30/13 at 1:44 PM of the medication storage room on the second floor, St. Joseph Unit revealed the following expired medications: - A house stock bottle of GeriCare Multi-Vitamins (supplement) with 100 tablets and an expiration date of 3/13; - A house stock bottle of Ibuprofen (used for pain, headache, fever) with 100 tablets and an expiration date of 5/13; - Ciprofloxacin (an antibiotic) was prescribed on 9/11/12 to R39 which the resident brought with her upon admission to the facility on 9/26/12. R39's Ciprofloxacin had 13 tablets remaining and was expired as of 8/14/13. 2. An observation on 8/30/13 at 2:05 PM of the second floor, St. Joseph Unit medication cart revealed the following expired medication and supplements: - A house stock bottle of Aspirin (used for fever), expired in 4/13; - Two (2) containers of ProCel, (house stock protein supplement) stock, both expired in 2/12.	F 431		

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F 431	Continued From page 6 On 8/30/13 at 2:15 PM in an interview, findings were confirmed by E7 (Registered Nurse/ RN) who then disposed of the expired items from the second floor St. Joseph unit. 3. An observation on 8/30/13 at 2:20 PM of the medication storage room on the first floor, Holy Family Unit revealed the following expired medication: - A house stock bottle of GeriCare Multi-Vitamins (supplement) with 100 tablets and an expiration date of 3/13. On 8/30/13 at 2:30 PM in an interview, E8 (RN) confirmed the findings and disposed of the expired multivitamins. 4. An observation on 9/3/13 at 8:25 AM of a second medication storage room on the second floor, which was labelled "Clean Utility Room," revealed the following expired medication: - Four house stock bottles of Maalox Advanced Regular strength (antacid) expired in 11/12. On 9/3/13 at 8:45 AM an interview was conducted with E3 (Director of Nursing). E3 stated that medications in this room were generally used by the Sisters of this religious order. However, E3 confirmed that the four bottles of Maalox were house stock used for the residents and were expired. The facility failed to remove expired medications from three medication storage rooms and one medication cart.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 7 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	1. No Residents were affected by the facility not monitoring chemical concentrations of the wash water in the laundry as the technology of the machine sounds a alarms and will not operate when chemical concentrations fall below 125 ppm. 2. No Residents had the potential to be affected as per CMS Interpretive Guidance issued January 25, 2013 F 441 states; "Laundry processing conducted within facilities typically occurs in a low water temperature environment. Many laundry items are composed of materials that cannot withstand a chlorine bleach rinse and remain intact. The chlorine bleach rinse is not required for all laundry items processed in low temperature washing environments due to the availability of modern laundry detergents that are able to produce hygienically clean laundry without the presence of chlorine bleach." Additionally, the guidance states facilities are not required to maintain a record of water temperatures during laundry processing cycles. 3. Facility Policies have been changed	9-20-13

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F 441	Continued From page 8 Based on observations, interviews and other facility documentation, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to monitor the chemical concentration of the laundry wash water and the temperatures were as low as 146 degrees Fahrenheit (F) for two (2), April and July 2013, out of eight (8) months from January 2013 though August 2013. Additionally, the facility failed to maintain appropriate handwashing technique based on an observation that was made during the dining observation on 8/29/13. Findings include: 1. Review of the facility's laundry policy revealed that the laundry wash water temperature was to be at 160 degrees F. Observation of the laundry on 8/30/13 at approximately at 8:55 AM revealed the washers were not in operation at this time. Therefore, the water temperatures couldn't be measured. Review of chemical vendor reports on 8/30/13 revealed that the facility monitored the wash water temperatures and chemical concentrations monthly. Review of the chemical vendor "Routine Preventative Maintenance Service Detail Report" from January 2013 to August 2013 revealed that the concentration of the chemical was about 150 PPM (parts per million). However, the April report was missing. The June report was missing the concentration of the chemical and the wash temperature was measured at 120 degrees F on	F 441	to reflect CMS Guidance to F441 and water temperatures has been removed. See Attachment D Monthly Service will continue to be conducted by an Eco-Lab representative and a service log will be dated and initialed by the representative See Attachment E 4. Service reports will be sent to the Maintenance Director monthly and records will be maintained in the laundry. Maintenance director will submit a report to the Infection Control Committee monthly for until all reports are correctly submitted for three months and then reported quarterly.	

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F 441	Continued From page 9 June 20, 2013. However, the facility had measured the laundry water temperature on June 20, 2013 at 160 degrees F. Also, the July 2013 report was missing. Review of the facility's "Daily round temperature" logs of the laundry water temperatures tested each morning, revealed that the temperatures varied. The logs revealed the following ranges: - from 146 to 160 degrees F in April 2013; - from 146 to164 degrees F in July 2013. On 9/3/13 at approximately 2:47 PM, in an interview, E6 (Housekeeping/Laundry Supervisor) stated that the chemical vendor did not come in to test the chemical concentration of the washer water for April and July 2013. E6 stated that the facility was going through a transition with the chemical vendor and they were getting a new representative. She stated that the "testing for the washers just felt through the cracks... the new guy said this will never happen again". On 9/4/13 at approximately 9:00 AM, in an interview, E5 (Maintenance Director) stated that the temperature they recorded on their logs represented the water temperature going into the washer but this water then was mixed with cold water, and therefore, the temperature was not maintained at 160 degrees F but was lower. The facility failed to monitor the chemical concentration of the wash water in the laundry when the water temperature was below 160 degrees F in April 2013 and July 2013. Findings were confirmed by E6 on 9/3/13 at 2:47 PM and by E5 on 9/4/13 at 9 AM as noted above. 2. The facility's policy and procedure entitled,	F 441	1. No Residents were affected by E9 not washing her hands after rinsing the salad dressing cap as she returned to sink and washed her hands correctly prior to serving Residents. 2. All Residents have the potential to be affected by staff not washing hands after rinsing items. 3.Staff who serve in the dining rooms will be notified of the need to wash hands after rinsing items and this will be added to Monthly Infection Control Spot Checks. Findings will be reviewed monthly by the Infection Control Compliance Officer. See Attachment F 4. Infection Control Spot Check findings will be reported to the CQI Committee quarterly	10-1-13

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F 441	Continued From page 10 "Handwashing", last revised 4/97, noted, "...turn faucet off with a paper towel..." During the dining observation on 8/29/13 at 12:05 PM, an observation was made by two surveyors of E9 (Unit Sister), who took a salad dressing cap that was soiled with salad dressing to the sink and rinsed/washed it. E9 washed the cap, she shut off the sink faucet with her bare hand and failed to wash her hands. Then, E9 returned to the salad cart and started to place items back into the refrigerator. The surveyor advised E9 of the observation and need to wash her hands due to possible contamination which she did. The facility failed to maintain proper handwashing technique to help prevent the development and transmission of disease and infection as part of the infection control program.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide or obtain laboratory services to meet the needs of its residents, including the timeliness of the services for one (R9) out of 17 Stage 2 sampled residents. Findings include:	F 502	1. Labs were drawn for R9 prior to survey and labs were within normal range for Resident. 2. All Residents have the potential to be affected by late laboratory draws. 3. Review of laboratory orders and results will be conducted by administrative nurses monthly and results documented. Labs to be drawn each month will be forwarded to the Medical Secretary. See Attachment G	9/27/13

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F 502	Continued From page 11 R9's doctor ordered that the resident have the following blood tests on a regular basis: - a basic metabolic panel (BMP) (set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance) every three months; - an Hemoglobin and Hematocrit (H/H) every three months (Hemoglobin is the protein contained in red blood cells that is responsible for delivery of oxygen to the tissues. Hematocrit measures the volume of red blood cells compared to the total blood volume.); - a lipid profile every six months (tests used to gauge a person's risk for heart conditions; lipid profile measures fats and fatty substances in the body). Review of R9's record, revealed that the last lipid profile was done on 1/30/13 and the last BMP and complete blood count which included an H/H was done on 3/22/13. There was no BMP nor H/H in the resident's record that was due in 6/13 as ordered by R9's doctor. There was no lipid profile in the resident's record that was due in 7/13 as ordered by R9's doctor. On 9/3/13 at 3:15 PM, in an interview, E3 (Director of Nursing) stated that the lab work/blood tests were not noted in any residents' treatment records or in any separate laboratory books. E3 went through the lab sheets in R9's record and stated that there were no BMP or H/H reports in the record for June 2013 and no lipid profile in the record for July 2013. E3 stated that she did audits to keep track of when the lab work was due. She went to get the lab work audits and reviewed them. Upon return, E3 confirmed that	F 502	Lab logs will be maintained in medical for DON to review and double check to ensure accuracy and that labs are done in a timely manner while minimizing invasive procedures. 4. Results of monthly laboratory log audits will be reported quarterly to the CQI until 100% accuracy has been noted for twelve months.	

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JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 12 according to her audits she missed the lab work for R9. E3 confirmed that the resident did not have the BMP and H/H that was due in 6/13 nor the lipid profile that was due in 7/13 as ordered by R9's doctor. The facility failed to implement an effective system to provide laboratory services in a timely manner as ordered by R9's doctor. Findings were confirmed by E3 on 9/3/13 at 3:15 PM.	F 502		

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
Division of Long Term Care Residents Protection (DLTCRP)

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: September 4, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from August 29, 2013 through September 4, 2013. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage II survey sample was 17.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	Cross refer to the CMS 2567-L survey report dated 9/4/13, F278, F323, F431, F441, and F502.

Provider's Signature Dr Cecile Zeringue Title Adm Date 9/23/13

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	Cross refer to the CMS 2567-L survey report dated 9/4/13, F278, F323, F431, F441, and F502.	